AL WISEWOMAN Health Coaching/LSP/Reassessment Contact Form

Date: ___________________________ ABCCEDP Provider: ____

Client Name: ____ DOB: _____________ Cell Phone: (________) ____________

First Middle Initial Last

Address: ____

Email: ____ Telephone: (________) _________________________________

Referred to Health Coaching for: (check all that apply) **Hypertension** **Diabetes** **Hyperlipidemia** **Weight** **Smoking Cessation**

Does patient wish to participate in Health Coaching? Yes ☐ No ☐ Not at this time☐

If no and if applicable, was patient provided with community resource materials? Yes ☐ No ☐

____

Was a referral made on patient's behalf? Yes ☐ No ☐ Where? ____

HC SESSION 1: ________________________ Face to Face (required for 1st) ____________minutes

Date **Type** **Duration**

Topics/Goals Completed: ____

Is patient on hypertension medications? Yes No How does patient purchase medications? ____________________________________

Does patient need a referral to compassionate care program for hypertension medications? Yes ☐ No ☐ (document referral)

Adherence Plan: ____

Does patient have access to home BP monitoring? Yes ☐ No ☐

Were community BP monitoring resources discussed or provided? Yes ☐ No ☐

Does patient plan to monitor BP? Yes ☐ No ☐

Is patient a smoker? Yes ☐ No ☐ Was a smoking cessation referral made? Yes ☐ No ☐ (document referral)

Why not? ____

Nutritional Counseling appointment made? Yes ☐ **No** ☐ **Date of Appointment:** ____

What incentive items did the patient receive: Pill Box Yes☐ No ☐ Stretch Band Yes☐ No ☐ Blood Pressure Monitor Yes☐ No ☐

HC SESSION 2: ______________________ __________________________ _______________minutes

Date **Type** **Duration**

Person completing session: ____

Topics /Goals Completed: ____

Is patient a smoker? Yes ☐ No ☐ Was a smoking cessation referral made? Yes ☐ No ☐ (document referral)

Why not? ____

Community Referrals made for: Utility Bills ☐ Housing ☐ Medication Assistance ☐ Food ☐ Clothing ☐ Transportation ☐ Domestic Violence ☐

Mental Health ☐ Suicide ☐ Chemical Dependency ☐ Employment ☐ Parenting/Grandparenting ☐ Household items ☐ Other:_____________

HC SESSION 3: ______________________ _________________________ ______________minutes

Date **Type** **Duration**

Topics/Goals Completed: ____

Is patient a smoker? Yes ☐ No ☐ Was a smoking cessation referral made? Yes ☐ No ☐ (document referral)

Why not? ____

Why not? ____

Community Referrals made for: Utility Bills ☐ Housing ☐ Medication Assistance ☐ Food ☐ Clothing ☐ Transportation ☐ Domestic Violence ☐

Mental Health ☐ Suicide ☐ Chemical Dependency ☐ Employment ☐ Parenting/Grandparenting ☐ Household items ☐ Other:_____________

Health Coaching Completion Date:_______________

Patient: ___________________________ Tracking #: ______________________________

<u>Hypertension Medication Follow up</u>: Must be completed on all patients beginning hypertension medications

Was follow up completed within 10 working days following an addition/change in hypertension medication? Yes ☐ No ☐ Date: ______________

Is patient's medication plan working? ____

Changes to plan: ____

Was patient referred to USDA lifestyle Program? Yes ☐ No ☐

Additional Health Coaching Activities Including: phone contact, support groups, follow up etc.

Date	Activity

Community Referrals

Date	Agency	Follow up (required)

Date: __________________ Weight: _____________ Blood Pressure: ______________ Taken By: _________________

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Date: __________________ Weight: _____________ Blood Pressure: ______________ Taken By: _________________

<u>7 Month Follow-up Assessment:</u> Date: ________________________ Type: __________________________ Duration: ________

Health issues reviewed: BP ____ Meds ____ Smoking ____ Diet ____ Physical Activity _____ Quality of life issues ______

Health Plan: ____

____

WISEWOMAN Rescreening date: ___________/___________/___________ **(12 to 18mos)**

Annual Reminder Call completed on: ____

(Revised: 06/24/2015)